

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Mary'sCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary'sCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Edward Baer

3. (b) Social Security Number

4. Sex

m

5. Color or race

wh

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

5-12-45

8. AGE:

Years

Months

Days

If less than one day

9

hrs. min.

8. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

19.

19.

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-1948 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-21-1948 to 5-21-1948and that I last saw him alive on 5-21-1948Immediate cause of death Brain tumor

DURATION

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

P.M.V. Palmer

M. D. or other

Address

PalmerDate signed 5-22-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATEMENT OF DEATH

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Name of physician: _____

6. Name of funeral home: _____

7. Name of next of kin: _____

8. Name of informant: _____

9. Name of witness: _____

10. Name of witness: _____

11. Name of witness: _____

12. Name of witness: _____

13. Name of witness: _____

14. Name of witness: _____

15. Name of witness: _____

16. Name of witness: _____

17. Name of witness: _____

18. Name of witness: _____

19. Name of witness: _____

20. Name of witness: _____

RECEIVED
MAY 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Mary's
City or town Rural Palmyra
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 min
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County St. Mary's
City or town Rural Palmyra
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ms name Beacham

3. (b) Social Security Number

4. Sex m 5. Color or race cds 6. (a) Single, married, widowed, or divorced ---

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 5-2-1948
6. (c) If alive, give age --- years

8. AGE: Years --- Months --- Days --- If less than one day --- hrs. 5 min.

9. Birthplace Palmyra MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Hoble Joseph Beacham
13. Birthplace Portland Maine

14. Maiden name Elsie Virginia Tate
15. Birthplace Montross Va

18. Informant Hoble Joseph Beacham
Address Palmyra

17. Burial Date thereof 5-2-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Interfaith
Location Palmyra MD

18. Funeral director Hoble Joseph Beacham
Address Palmyra MD

19. 5-2-48 19 48 N.R. Palmyra
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2-48 19 48 at 3:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from --- 19 --- to --- 19 ---

and that I last saw him alive on 5-2-48 19 ---

Immediate cause of death Beacham
with 5 months

Due to over work
and lifting
Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Beacham M. D. or other

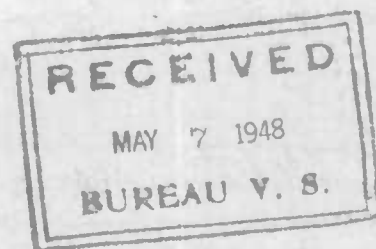
Address Palmyra MD Date signed 5-2-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

05315

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary'sCity or town Beachville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Beachville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Emma M. Cole

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Jim Cole

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Dec. 14, 1877

8. AGE:

Years

Months

Days

If less than one day

70?

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Mark Cooper

13. Birthplace

Maryland

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

B. W. Cole

Address

Beachville, Md.

17. Burial

Burial
(Burial, cremation, or removal. Which?)

Date thereof

5-16-48
(month) (day) (year)

Cemetery or crematory

St. Peter's

Location

Ridge, Md.

18. Funeral director

J. B. Johnson

Address

Leonardtown

19. (Date rec'd by registrar)

5/16 48 Casualty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 141948 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Death when first seen to _____ 19____

and that I last saw h. _____ alive on _____ 19____

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Julian J. Sauer

M. D. or other _____

Address Woodstock, Md Date signed 5/14/48

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary'sCity or town Clements
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County ST. MARY'SCity or town CLEMENTS
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

STUART HOBBS EDMONDS

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife WOOD BARNER EDMONDS6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) OCT 25, 18788. AGE: Years 71 Months 6 Days 18 It less than one day
hrs. min.9. Birthplace Southbridge Mass.
(Town, county, and state)10. Usual occupation Architect (RETIRED)11. Industry or business SAME12. Name Charles S. Edmonds13. Birthplace Mass14. Maiden name Altha Hobbs15. Birthplace Mass16. Informant Wood Barnar EdmondsAddress Clements Md.17. Burial Date thereof May 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Christ Church CemeteryLocation Chapin Maryland18. Funeral director W. C. MATTINGLEY SONSAddress ROBERTSTOWN, MD.19. Sp. 15-48 Registrar(Date rec'd by registrar) 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13 1948 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to May 13 1948and that I last saw him alive on May 13 1948Immediate cause of death Coronary ThrombosisDURATION 5 min.Due to Generalized Arteriosclerosis 10 YearsDue to Hypertension 10 yearsOther conditions Prostatic Hypertrophy 3 years

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

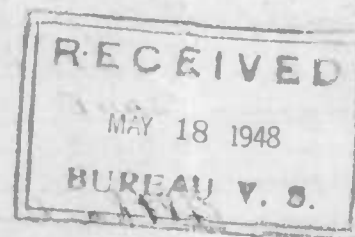
Means of injury

Injured at work?

23. SIGNATURE Mr. J. P. Smith MD

M. D. or other

Address Lepington Park MdDate signed 5-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 262

1. PLACE OF DEATH:

County St. Marys
 City or town Rt # 5 (Rural) Mechanicsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank C. Jones

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Clura B. Jones

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 29, 1890

8. AGE:

Years

Months

Days

It less than one day

58

1

3

hrs.

min.

9. Birthplace

Ohio

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

John Jones

13. Birthplace

Ohio

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Clura B. Jones

Address

618 -12th St. N.W. Washington D.C.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 5/3/48

(month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director

W.W. Chambers

Address Washington, D.C.

19. 5-3 1948

(Date rec'd by registrar)

Camalier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Dead when first seen 1948

and that I last saw him alive on 1948

Immediate cause of death

DURATION

Head injury, trauma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05318

Reg. Dist. No. 282

1. PLACE OF DEATH:

County *St. Mary's*City or town *Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry Simmons Jones

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

*married*6. (b) Name of husband or wife *Mary B.*

7. Birth date of

deceased (mo., day, yr.)

*June 20, 1917*6. (c) If alive, give age *29* years

8. AGE:

Years

Months

Days

If less than one day

30

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

O.P. Phone employed

11. Industry or business

Harry M. Jones

12. Name

13. Birthplace

Maryland

14. Maiden name

Virginia Bramble

15. Birthplace

Maryland

16. Informant

Harry M. Jones

Address

Leonardtown, Md.

17. Burial

(Burial, cremation, or removal, which)

Date thereof

5-22-48

Cemetery or crematory

St. Paul M.C.

Location

Leonardtown

18. Funeral director

P.B. Robinson

Address

Leonardtown, Md.

19. Date rec'd by registrar

5/22/48

19.

*48**Caecaleen*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *St. Mary's*City or town *Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

World War II

3. (b) Social Security Number

212-01-1886

MEDICAL CERTIFICATION

20. DATE OF DEATH

*May 19*19 *48* at *4 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Death when first seen

and that I last saw him alive on 19

Immediate cause of death

Asphyxia

DURATION

immediate

Due to

Drowning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *5/19/48*Where did injury occur? *Leonardtown St. Mary's Md.*
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? *Brighton Bay*Means of injury *Drowning* Injured at work? *no*

23. SIGNATURE

Julia I. Saw

M. D. or other

Address *Leonardtown, Md.* Date signed *5/19/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH,

Reg. Dist. No. 782

1. PLACE OF DEATH:

County St. Mary's
 City or town St. Mary's
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's
 City or town St. Mary's
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Barbara Jean Long

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April 25 19488. AGE: Years _____ Months _____ Days 23 If less than one day _____ hrs. _____ min.9. Birthplace MD (Town, county, and state)10. Usual occupation Teacher

11. Industry or business _____

12. Name Joe A. Long13. Birthplace MD14. Maiden name May Susan Sharp15. Birthplace MD16. Informant Joe A. LongAddress St. Mary's17. Burial Date thereof 5/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Andrew'sLocation Bushwood18. Funeral director Wm. C. Heavens, Inc.Address St. Mary's19. 5/19 1948 Registrar Cam...

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1948 at 4:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 1948 to May 19 1948 and that I last saw him alive on May 1 1948

Immediate cause of death _____

DURATION

Due to Spina Bifida

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James A. Cam... M. D. or otherAddress St. Mary's Date signed 5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 284

93d 05320

1. PLACE OF DEATH:

County St. Marys
 City or town Leonardtown Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Philip Long

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ida Marie Long

7. Birth date of deceased (mo., day, yr.)

Dec 18 - 18826. (c) If alive, give age 55-6 years

8. AGE:

Years

Months

Days

(If less than one day)

65517hrs.min.

9. Birthplace

Praville St Marys Maryland
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

same

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St MarysCity or town Praville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 May 48 at 4:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 May 48 to 27 May 48and that I last saw him alive on 27 May 48

Immediate cause of death

Cerebral hemorrhagehypertensionarteriosclerosiscardiovascular disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Roy Lynther MD

Mechanicville Md 27 May 48

Date signed

RECEIVED

JUN 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **St. Marys County**
City or town..... **U.S. Naval Air Station, Patuxent River, Md.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... **22 months**
Hospital, institution, or street address where death occurred:
Dispensary, US NAS, Patuxent River, Maryland
How long in hospital or institution?..... **Pronounced dead on arrival**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... **Wisconsin** County.....
City or town..... **Shelton, Wisconsin**
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **Rt. 1, Box 1**
(If rural, give LOCATION)
2.(a) If veteran, name war..... **World War II** ✓

3.(a) FULL NAME

Calvin (no middle name) LUDVIGSEN

3.(b) Social Security Number

4. Sex..... **Male**
5. Color or race..... **White**
6.(a) Single, married, widowed, or divorced..... **Married**

6.(b) Name of husband or wife..... **Nancy Hortense Ludvigsen**

7. Birth date of deceased (mo., day, yr.)..... **2-26-27**

8. AGE: Years..... **21** Months..... **2** Days..... **6**
If less than one day..... hrs. min.

9. Birthplace..... **Wisconsin**
(Town, county, and state)

10. Usual occupation..... **Yeoman Third Class**

11. Industry or business..... **U. S. Navy**

12. Name..... **John Ludvigsen**

13. Birthplace..... **Denmark**

14. Maiden name..... **Unknown**

15. Birthplace..... **Norway**

16. Informant..... **Naval Records**

17. Address..... **Transportation**
Removal
(Burial, cremation, or removal. Which?)

Date thereof..... **5-3-48**
(month) (day) (year)

Cemetery or crematory.....

Location..... **Ladysmith, Wisconsin**

18. Funeral director..... **P.B. Robinson's Funeral Home**

Address..... **Leonardtown, Maryland**

19. **5/4**..... **48**
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 2** 19..... **48** at..... **7:00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased **on**
May 2 19..... **48** **or**
and that I last saw him **dead** **May 2** 19..... **48**

Immediate cause of death..... **Fracture, skull.**
Compound.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Accident** Date of..... **5-2-48**
Where did injury occur?..... **Great Mills, St. Marys, Md.**
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... **On roadside**

Means of injury..... **Struck by automobile** Injured at work?..... **No**

23. SIGNATURE.....

D. C. DIXON, LTJG MC USNR

M. D. or other

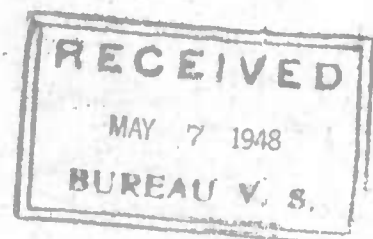
Address..... **US NAS, Patuxent River, Md.** Date signed..... **5-3-48**

MARGIN RESERVED FOR BINDING

9-43-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05322

Reg. No. G 116 JUN 10 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 882

1. PLACE OF DEATH:

County St. Mary's
City or town Lexington Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State South Carolina County
City or town Highpoint
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME

Edward Miller

3. (b) Social Security Number

241-18-0088

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Susan Miller

7. Birth date of deceased (mo., day, yr.) Unknown 7-7-1912

8. AGE: Years 35 Months 36? Days hrs. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation labor

11. Industry or business

12. Name Wheel Miller

13. Birthplace South Carolina

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant William Glenn

Address Lexington Park, Md.

17. Transportation Date thereof 6-3-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Chester, South Carolina

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 6-3 1948 Comaler
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1948 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead when first seen to seen 1948

and that I last saw him alive on 19

Immediate cause of death

Hemorrhage

Due to Cerebral vascular accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William I. Glenn M. D. or other

Address Leonardtown, Md. Date signed 6/1/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05323

1. PLACE OF DEATH:

County St. Mary's
 City or town Compton Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Compton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Emma Miles

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Charles Miles
 6.(c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Compton St. Mary's Maryland
(Town, county, and state)10. Usual occupation House Wife11. Industry or business none12. Name unknown

13. Birthplace _____

14. Maiden name unknown

15. Birthplace _____

16. Informant Charles MilesAddress Compton Maryland17. Burial Date thereof May 17 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Francis Xavier'sLocation Compton Maryland18. Funeral director W.C. MartinAddress Leonardtown Maryland19. 5/18 19 48 Registrar Paul A. Cavalier
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 19 48 to 19
 and that I last saw him alive on May 14 19 48

Immediate cause of death Sudden Death
Probably coronary thrombosis
 Due to unknown

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul A. Cavalier M. D. or other _____Address Leonardtown Date signed 5/18/48

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hours
 Hospital, institution, or street address where death occurred:
St. Mary's Hospital
 How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town Clements
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Morgan, Samuel Joseph

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife Margaret G. Morgan

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1905

8. AGE: Years Months Days If less than one day
42 7 19 hrs. min.

9. Birthplace Maryland St. Mary's Md
 (Town, county, and state)

10. Usual occupation Busch driver

11. Industry or business same

12. Name Henry R. Morgan

13. Birthplace St. Mary's Co

14. Maiden name Katharine Galdeston

15. Birthplace St. Mary's Co

16. Informant Mr. Margaret G. Morgan

Address Clements Maryland

17. Burial Date thereof May 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Maryland

18. Funeral director W. C. McKinley Sons

Address Leonardtown Maryland

19. 5/15/48 Clements
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 19 48 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 May 19 48 to 14 May 19 48

and that I last saw him alive on 14 May 19 48

Immediate cause of death Cardiac decompensation DURATION 24 hrs.

Due to Coronary thrombosis?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

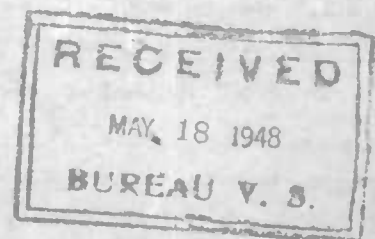
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Roy Emyther, M.D. M. D. or other

Address Mechanicville, Md. Date signed 14 May 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

FILE No. G 116 JUN -7 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05325

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
City or town Parkville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Parkville Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St. Mary's
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. A 70 #1 Mechanicsville Md
(If rural, give LOCATION)
2(a) if veteran, name war

3. (a) FULL NAME

James Lewis Duade

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. James L. Duade

7. Birth date of deceased (mo., day, yr.) March 22-1908 6. (c) If alive, give age years

8. AGE: Years 40 Months 39 Days 7 If less than one day hrs. min.

9. Birthplace Parkville St. Mary's Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business same

12. Name James S. Duade

13. Birthplace St. Mary's Co

14. Maiden name Mary D. Williams

15. Birthplace St. Mary's Co

16. Informant Mr. James S. Duade

Address Mechanicsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 31-1948
(month) (day) (year)

Cemetery or crematory St. Joseph Cemetery

Location Maryland

18. Funeral director W. C. Mattingly Sons

Address Seamaster Maryland
528 48 Calumet
19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead when first seen 1948

and that I last saw him alive on 1948

Immediate cause of death Acute cardiac distention

Due to Coronary thrombosis

Due to 1 week

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

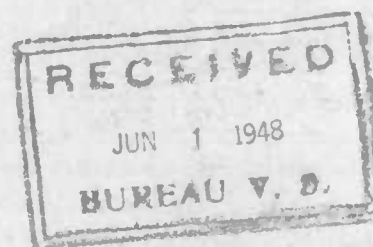
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Davis MD M. D. or other
Address Bedford, Md Date signed 5/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05326

Reg. Dist. No. 29/

1. PLACE OF DEATH:

County St. Marys
 City or town Leonardtown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
St. Marys Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
 City or town Great Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lillian A. Robertson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife William C. Robertson
 6.(c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) March 4 - 1905
 8. AGE: Years 43 Months 2 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Great Mills St. Marys Md
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Thomas W. Bean
 13. Birthplace St. Marys Co
 14. Maiden name Elizabeth E. Evans
 15. Birthplace St. Marys Co

16. Informant Mrs. Thomas E. Bean
 Address Great Mills Maryland

17. Burial Date thereof May 15 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Family
 Location Great Mills Md

18. Funeral director W. C. Matthews Sons
 Address Leonardtown Md

19. 8-11- 1948 P. Bean MD
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to May 10 1948
 and that I last saw him alive on May 10 1948

Immediate cause of death Nephritis
 DURATION 6 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

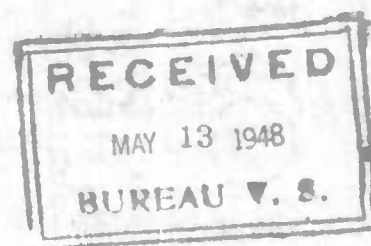
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. Bean MD M. D. or other

Address Great Mills Md Date signed 5-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

05327

49a

1. PLACE OF DEATH:

County St. Mary's
 City or town Fall Timbers Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:
Fall Timbers Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Fall Timbers
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Barbara L. Somerville
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife James L. Somerville
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb - 14 - 1859
 8. AGE: Years 89 Months 2 Days 18 I less than one day _____ hrs. _____ min.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948 at 4:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1948 to May 1 1948
 and that I last saw h. or alive on May 1 1948
 Immediate cause of death Carcinoma of Ovary DURATION 1 year
 Due to _____
 Due to _____
 Other conditions Generalized Carcinomatous
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Baltimore City Maryland
 (Town, county, and state)
 10. Usual occupation House
 11. Industry or business _____
 12. Name George F. Beaver
 13. Birthplace Unknown
 14. Maiden name Elizabeth Eifer
 15. Birthplace Unknown
 16. Informant Mr. Theodore E. Thomas
 Address Fall Timbers Maryland
 17. Burial Date thereof May 4 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Poplar Hill
 Location Valley Lee Maryland
 18. Funeral director W. C. Mattingly, Son
 Address Leonardtown Md
 19. 573 48 Cecelia
 (Date rec'd by registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Wm H. Parnell MD M. D. or other _____
 Address Leopington Park Md Date signed 5-2-48

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... St Marys
 City or town..... Lanham
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 weeks
 Hospital, institution, or street address where death occurred.....
St Marys Hospital
 How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St Marys
 City or town..... near California Pk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Justin R. Sypher

3. (b) Social Security Number

4. Sex.....

Male

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced.....

Married

6. (b) Name of husband or wife.....

Reck Withers

7. Birth date of deceased (mo., day, yr.).....

May 30 - 18746. (c) If alive, give age..... 71 years

8. AGE:

Years.....

74

Months.....

0

Days.....

0

If less than one day

..... hrs. min.

9. Birthplace.....

Philadelphia Pa

(Town, county, and state)

10. Usual occupation.....

Secretary

11. Industry or business.....

FATHER

12. Name.....

Joseph R. Sypher

13. Birthplace.....

Pa

MOTHER

14. Maiden name.....

Ally Inghel

15. Birthplace.....

Pa

16. Informant.....

Reck Sypher

Address.....

California or St Marys

17.....

(Burial, cremation, or removal, Which?)

Date thereof.....

May 8 1948

Cemetery or crematory.....

St Andrews Cemetery

Location.....

near California

18. Funeral director.....

W. C. Matthews Sons

Address.....

Leonardtown Md

19.....

(Date rec'd by registrar)

19.....

48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

5-30

19.....

48

at.....

40

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-8

19.....

48

to.....

5-30

19.....

48

and that I last saw him alive on.....

5-30

19.....

48

Immediate cause of death.....

Pneumonia

DURATION

Due to.....

Pneumonia

Due to.....

Complications of

Other conditions.....

acute

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. F. Greenwell

M. D. or other

Address.....

Leonardtown Md

Date signed.....

5-31-48

RECEIVED

JUN 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town Lemardtown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 hours
 Hospital, institution, or street address where death occurred:
Leonardtown Maryland
 How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town Charlotte Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Irving. Livingston Wild

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Robert Billings Wild
 6.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) March 12-1877
 8. AGE: Years 71 Months 2 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Red Bank New Jersey
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

12. Name Unknown

13. Birthplace _____

14. Maiden name Unknown

15. Birthplace _____

16. Informant F. O. Billingsworth

Address 2620 S.E. 74 St Portland Ore

17. Burial Date thereof May 26 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory All Souls Church 4th

Location Near Forest New Jersey

18. Funeral director W. C. Mattingley Sons

Address Leonardtown Maryland Md

19. 5/26-1948 Registrar Chancellor
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1948 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 days when first seen 19____
 and that I last saw him alive on _____ 19____

Immediate cause of death _____ DURATION _____

Retroperitoneal Hemorrhage 2 days

Due to Sacral aneurism aorta
Ruptured (abdominal) 1 yr.

Due to Arteriosclerosis

Other conditions Cirrhosis of Liver
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Ruptured Aneurism

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

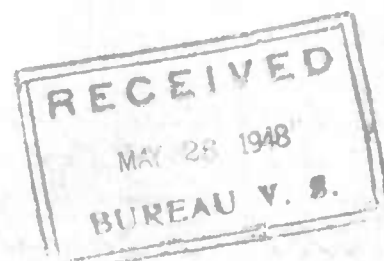
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul I. Saw M. D. or other _____

Address Leonardtown Md Date signed 5/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH:

County St. Mary'sCity or town St. Mary's
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

City or town Washington County P. C.City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 5-3-2-4 N. W.
(If rural, give LOCATION)2. (a) If veteran, name war World War II ✓

3. (a) FULL NAME

Joseph Wilson

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Evelyn Wilson

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 12, 19058. AGE: Years 42 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Spatter11. Industry or business Sup. cleaning12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Evelyn WilsonAddress 532 N. W. Wash. St. B.17. Burial Date thereof May 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington St. B.Location Washington St. B.18. Funeral director W. B. SnodgrassAddress Leonardtown, Md.19. 5/15 48 Cremation
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1948 at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Death when first seen

and that I last saw him alive on _____ 19____

Immediate cause of death _____

DURATION _____

Extreme Head injury immediateDue to Trauma.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/15/48Where did injury occur? Front Heel St. Mary's Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway Route 5Means of injury Automobile Injured at work? yes23. SIGNATURE John I. Lane M.D.
M. D. or otherAddress Legadon, Md. Date signed 5/17/48

RECEIVED

MAY 18 1948

BUREAU V. S.